Arizona Wic Special Formula Authorization Form
For Premature and Medically Fragile Infants

Client Name: _____

Date of Birth: _____ WIC Client ID: _____

The above infant has been identified by the WIC staff as being premature and/or medically fragile. Since powder formulas are not sterile, they should only be fed to these infants if directed and supervised by a doctor. WIC issues a concentrate contract formula to these infants if no other authorization by the doctor is received. WIC encourages the authorization of powder or concentrate formula when medically appropriate, since it lowers costs and enables WIC to serve more clients. Please complete the following information so WIC can provide the appropriate formula:

Please fully complete every section (1-7) to avoid delays in issuance.

1. Current Formula Request: *Please choose WIC contract formulas whenever possible.*

Contract Formulas
- ☐ Similac Advance EarlyShield
- ☐ Similac Sensitive Isomil Soy
- ☐ Similac Sensitive for Fussiness & Gas

Special Formulas
- ☐ Enfamil Premature LIPIL, 24 kcal (RTF only)
- ☐ Similac Special Care w/ iron, 24 kcal (RTF only)
- ☐ Similac Expert Care NeoSure (Powder and RTF)
- ☐ EnfaCare LIPIL (Powder and RTF)
- ☐ Other Special Formula: _____

2. Form of Formula: ☐ Powder ☐ Concentrate ☐ Ready-to-feed

3. Amount of Formula Per Day: _____
(Ad lib is an acceptable response)

4. Diagnosis for Special Formula:

☐ Prematurity ☐ GERD or reflux ☐ Dysphagia ☐ Failure to thrive (<5th percentile wt/length)
☐ Food allergy: _____ ☐ Other: _____

Note: Must be a specific medical diagnosis.

5. WIC Food <u>Restrictions</u>:

Infants 6-11 months will receive the following foods in addition to the formula prescribed. *Infants<6 mo will not receive foods. Please check any foods listed below that are **NOT** appropriate for the diagnosis.*

☐ All foods are appropriate for the client.

OR

WIC Foods	Do Not Give	Comment
Infant cereal	☐	_____
Infant Jarred Fruits and Vegetables	☐	_____

6. Length of Time Requested: # months (circle): 1 2 3 4 5 6 **OR** # weeks: _____

***Note:** Special formulas need to be renewed every **six** months.*

7. Print Provider Name/Title: _____ **Date:** _____

Provider Signature: _____ **Phone Number:** _____

Medical/Office Name and Address: _____

Local Nutritionist/State Approval

☐ Approved ☐ Not Approved Length of Authorization: From _____ To _____

Signature _____

Please visit http://www.azwic.gov/physicians.htm for additional forms or information.

Revised 04/2010